

ENGROSSED HOUSE BILL No. 1458

DIGEST OF HB 1458 (Updated April 2, 2003 8:28 PM - DI 104)

Citations Affected: IC 2-5; IC 12-15; noncode.

Synopsis: Medicaid prescription drugs. Extends the select joint commission on Medicaid oversight to December 31, 2008. Allows the office of Medicaid policy and planning (OMPP) to add a drug that has been approved by the FDA to the preferred drug list without prior approval from the board. Permits the board to add a drug that has been approved by the FDA to the preferred drug list. (Current law allows: (1) OMPP to add only new single source drugs to the preferred drug list without prior approval of the board; and (2) the board to add only new single source drugs to the preferred drug list.) Allows OMPP to limit access to prescription drugs for prescription drug program recipients to prevent fraud and inappropriate utilization. Makes a cross reference.

Effective: Upon passage; July 1, 2003.

Brown C

(SENATE SPONSORS — MILLER, SIMPSON, BREAUX)

January 15, 2003, read first time and referred to Committee on Public Health. February 19, 2003, amended, reported — Do Pass. February 25, 2003, recommitted to Committee on Ways and Means. February 27, 2003, amended, reported — Do Pass. March 3, 2003, read second time, ordered engrossed. Engrossed. March 4, 2003, read third time, passed. Yeas 75, nays 22.

SENATE ACTION March 10, 2003, read first time and referred to Committee on Health and Provider

Services.
April 3, 2003, amended, reported favorably — Do Pass.



First Regular Session 113th General Assembly (2003)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in this style type, and deletions will appear in this style type.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or *this style type* reconciles conflicts between statutes enacted by the 2002 Regular or Special Session of the General Assembly.

ENGROSSED HOUSE BILL No. 1458

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 2-5-26-15, AS ADDED BY P.L.256-2001.
SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
JULY 1, 2003]: Sec. 15. This chapter expires December 31, 2003.
2008

SECTION 2. IC 12-15-35-28, AS AMENDED BY P.L.107-2002, SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 28. (a) The board has the following duties:

- (1) The adoption of rules to carry out this chapter, in accordance with the provisions of IC 4-22-2 and subject to any office approval that is required by the federal Omnibus Budget Reconciliation Act of 1990 under Public Law 101-508 and its implementing regulations.
- (2) The implementation of a Medicaid retrospective and prospective DUR program as outlined in this chapter, including the approval of software programs to be used by the pharmacist for prospective DUR and recommendations concerning the provisions of the contractual agreement between the state and any

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1	other entity that will be processing and reviewing Medicaid drug
2	claims and profiles for the DUR program under this chapter.
3	(3) The development and application of the predetermined criteria
4	and standards for appropriate prescribing to be used in
5	retrospective and prospective DUR to ensure that such criteria
6	and standards for appropriate prescribing are based on the
7	compendia and developed with professional input with provisions
8	for timely revisions and assessments as necessary.
9	(4) The development, selection, application, and assessment of
10	interventions for physicians, pharmacists, and patients that are
11	educational and not punitive in nature.
12	(5) The publication of an annual report that must be subject to
13	public comment before issuance to the federal Department of
14	Health and Human Services and to the Indiana legislative council
15	by December 1 of each year.
16	(6) The development of a working agreement for the board to
17	clarify the areas of responsibility with related boards or agencies,
18	including the following:
19	(A) The Indiana board of pharmacy.
20	(B) The medical licensing board of Indiana.
21	(C) The SURS staff.
22	(7) The establishment of a grievance and appeals process for
23	physicians or pharmacists under this chapter.
24	(8) The publication and dissemination of educational information
25	to physicians and pharmacists regarding the board and the DUR
26	program, including information on the following:
27	(A) Identifying and reducing the frequency of patterns of
28	fraud, abuse, gross overuse, or inappropriate or medically
29	unnecessary care among physicians, pharmacists, and
30	recipients.
31	(B) Potential or actual severe or adverse reactions to drugs.
32	(C) Therapeutic appropriateness.
33	(D) Overutilization or underutilization.
34	(E) Appropriate use of generic drugs.
35	(F) Therapeutic duplication.
36	(G) Drug-disease contraindications.
37	(H) Drug-drug interactions.
38	(I) Incorrect drug dosage and duration of drug treatment.
39	(J) Drug allergy interactions.
40	(K) Clinical abuse and misuse.
41	(9) The adoption and implementation of procedures designed to
42	ensure the confidentiality of any information collected, stored,



1	retrieved, assessed, or analyzed by the board, staff to the board, or
2	contractors to the DUR program that identifies individual
3	physicians, pharmacists, or recipients.
4	(10) The implementation of additional drug utilization review
5	with respect to drugs dispensed to residents of nursing facilities
6	shall not be required if the nursing facility is in compliance with
7	the drug regimen procedures under 410 IAC 16.2-3-8 and 42
8	CFR 483.60.
9	(11) The research, development, and approval of a preferred drug
10	list for:
11	(A) Medicaid's fee for service program;
12	(B) Medicaid's primary care case management program; and
13	(C) the primary care case management component of the
14	children's health insurance program under IC 12-17.6;
15	in consultation with the therapeutics committee.
16	(12) The approval of the review and maintenance of the preferred
17	drug list at least two (2) times per year.
18	(13) The preparation and submission of a report concerning the
19	preferred drug list at least two (2) times per year to the select joint
20	commission on Medicaid oversight established by IC 2-5-26-3.
21	(14) The collection of data reflecting prescribing patterns related
22	to treatment of children diagnosed with attention deficit disorder
23	or attention deficit hyperactivity disorder.
24	(b) The board shall use the clinical expertise of the therapeutics
25	committee in developing a preferred drug list. The board shall also
26	consider expert testimony in the development of a preferred drug list.
27	(c) In researching and developing a preferred drug list under
28	subsection (a)(11), the board shall do the following:
29	(1) Use literature abstracting technology.
30	(2) Use commonly accepted guidance principles of disease
31	management.
32	(3) Develop therapeutic classifications for the preferred drug list.
33	(4) Give primary consideration to the clinical efficacy or
34	appropriateness of a particular drug in treating a specific medical
35	condition.
36	(5) Include in any cost effectiveness considerations the cost
37	implications of other components of the state's Medicaid program
38	and other state funded programs.
39	(d) Prior authorization is required for coverage under a program
40	described in subsection (a)(11) of a drug that is not included on the
41	preferred drug list.

(e) The board shall determine whether to include a single source



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1	covered outpatient drug that is newly approved by the federal Food and
2	Drug Administration on the preferred drug list not later than sixty (60)
3	days after the date on which the manufacturer notifies the board in
4	writing of the drug's approval. However, if the board determines that
5	there is inadequate information about the drug available to the board
6	to make a determination, the board may have an additional sixty (60)
7	days to make a determination from the date that the board receives
8	adequate information to perform the board's review. Prior authorization
9	may not be automatically required for a single source drug that is newly
10	approved by the federal Food and Drug Administration, and that is:
11	(1) in a therapeutic classification:
12	(A) that has not been reviewed by the board; and
13	(B) for which prior authorization is not required; or
14	(2) the sole drug in a new therapeutic classification that has not
15	been reviewed by the board.
16	(f) The board may not exclude a drug from the preferred drug list
17	based solely on price.
18	(g) The following requirements apply to a preferred drug list
19	developed under subsection (a)(11):
20	(1) The office or the board may require prior authorization for a
21	drug that is included on the preferred drug list under the following
22	circumstances:
23	(A) To override a prospective drug utilization review alert.
24	(B) To permit reimbursement for a medically necessary brand
25	name drug that is subject to generic substitution under
26	IC 16-42-22-10.
27	(C) To prevent fraud, abuse, waste, overutilization, or
28	inappropriate utilization.
29	(D) To permit implementation of a disease management
30	program.
31	(E) To implement other initiatives permitted by state or federal
32	law.
33	(2) All drugs described in IC 12-15-35.5-3(b) must be included on
34	the preferred drug list.
35	(3) The office may add a new single source drug that has been
36	approved by the federal Food and Drug Administration to the
37	preferred drug list without prior approval from the board.
38	(4) The board may add a new single source drug that has been
39	approved by the federal Food and Drug Administration to the
40	preferred drug list.

(h) At least two (2) times each year, the board shall provide a report

to the select joint commission on Medicaid oversight established by



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1	IC 2-5-26-3. The report must contain the following information:
2	(1) The cost of administering the preferred drug list.
3	(2) Any increase in Medicaid physician, laboratory, or hospital
4	costs or in other state funded programs as a result of the preferred
5	drug list.
6	(3) The impact of the preferred drug list on the ability of a
7	Medicaid recipient to obtain prescription drugs.
8	(4) The number of times prior authorization was requested, and
9	the number of times prior authorization was:
10	(A) approved; and
11	(B) disapproved.
12	(i) The board shall provide the first report required under subsection
13	(h) not later than six (6) months after the board submits an initial
14	preferred drug list to the office.
15	SECTION 3. IC 12-15-35-28.7, AS ADDED BY P.L.107-2002,
16	SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
17	JULY 1, 2003]: Sec. 28.7. (a) The board shall submit the initial
18	approved preferred drug list to the office not later than August 1, 2002.
19	(b) Except as permitted under subsection (g), the office may not
20	further restrict the status of a drug in the Medicaid program or the
21	children's health insurance program until the board reviews a
22	therapeutic classification and the office implements the therapeutic
23	classification on the preferred drug list.
24	(c) The office shall provide advance notice to providers of the
25	contents of the preferred drug list submitted by the board under
26	subsection (a).
27	(d) Notwithstanding IC 12-15-13-6, the office shall implement any
28	change in the preferred drug list not later than thirty (30) days after the
29	date the board submits the amended list to the office.
30	(e) Except as provided by section 28(g)(3) of this chapter, the
31	office may not implement a preferred drug list or an amendment to the
32	preferred drug list that has not been approved by the board.
33	(f) The office may not require prior authorization for a drug that is
34	excluded from the preferred drug list unless the board has made the
35	determinations required under section 35 of this chapter.
36	(g) The office may adopt rules under IC 4-22-2 necessary to carry
37	out this chapter.
38	SECTION 4. IC 12-15-35-43.5, AS ADDED BY P.L.107-2002,
39	SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
40	JULY 1, 2003]: Sec. 43.5. (a) The board, the therapeutics committee,
41	or the office may not release proprietary or confidential information

obtained as part of the development, implementation, or maintenance



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1	of a preferred drug list under this chapter.
2	(b) Information described in subsection (a) is confidential for
3	purposes of IC 5-14-3-4(a)(1).
4	SECTION 5. IC 12-15-35.5-2.5, AS ADDED BY P.L.107-2002,
5	SECTION 23, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
6	JULY 1, 2003]: Sec. 2.5. As used in this chapter, "unrestricted access"
7	means the ability of a recipient to obtain a prescribed drug without
8	being subject to limits or preferences imposed by the office or the
9	board for the purpose of cost savings except to address situations
.0	described in IC 12-15-35-28(a)(8)(A) through (K) and as provided
1	under IC 12-15-35-8 and section 7 of this chapter.
2	SECTION 6. P.L.107-2002, SECTION 36, IS AMENDED TO
.3	READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: SECTION
4	36. (a) As used in this SECTION, "office" refers to the office of
. 5	Medicaid policy and planning.
6	(b) The office shall develop a federal Medicaid waiver application
7	under which a prescription drug program may be established or
8	implemented to provide access to prescription drugs for low-income
9	senior citizens.
20	(c) Before the office may submit an application for a federal
21	Medicaid waiver that will have an effect on the Indiana prescription
22	drug program established under IC 12-10-16, the following must occur:
23	(1) The office shall submit the proposed Medicaid waiver to the
24	prescription drug advisory committee established under this act.
25	(2) The prescription drug advisory committee must review, allow
26	public comment, and approve the proposed Medicaid waiver.
27	(d) A prescription drug program established or implemented by the
28	office or a contractor of the office under this SECTION may only not
29	limit access to prescription drugs for prescription drug program
30	recipients, except under the following circumstances:
31	(1) Access may be limited to the extent that restrictions are in
32	place in the Medicaid program on the date of enactment of this
33	act.
34	(2) Access may be limited to prevent the following:
35	(A) Fraud.
86	(B) Abuse.
37	(C) Waste.
88	(D) Overutilization of prescription drugs.
39	(E) Inappropriate utilization of prescription drugs.
10	(e) Changes to a prescription drug program that:
1	(1) is established or implemented by the office or a contractor of
12	the office under this SECTION; and



1	(2) from the Indiana managintian days account	
1	(2) uses money from the Indiana prescription drug account	
2	established under IC 4-12-8-2;	
3	must be approved by the prescription drug advisory committee	
4	established under this act.	
5	(f) Before July 1, 2002, the office shall apply to the United States	
6	Department of Health and Human Services for approval of any waiver	
7	necessary under the federal Medicaid program to provide access to	
8	prescription drugs for low income senior citizens.	
9	(g) A Medicaid waiver developed under this SECTION must limit	
0	a prescription drug program's state expenditures to funding	
1	appropriated to the Indiana prescription drug account established under	
2	IC 4-12-8-2 from the Indiana tobacco master settlement agreement	
3	fund.	
4	(h) The office may not implement a waiver under this SECTION	
5	until the office files an affidavit with the governor attesting that the	
6	federal waiver applied for under this SECTION is in effect. The office	
7	shall file the affidavit under this subsection not later than five (5) days	
8	after the office is notified that the waiver is approved.	
9	(i) If the office receives a waiver under this SECTION from the	
20	United States Department of Health and Human Services and the	
21	governor receives the affidavit filed under subsection (f), the office	
22	shall implement the waiver not more than sixty (60) days after the	
23	governor receives the affidavit.	
24	SECTION 7. An emergency is declared for this act.	





COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1458, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Delete the title and insert the following:

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 12-15-35-28, AS AMENDED BY P.L.107-2002, SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 28. (a) The board has the following duties:

- (1) The adoption of rules to carry out this chapter, in accordance with the provisions of IC 4-22-2 and subject to any office approval that is required by the federal Omnibus Budget Reconciliation Act of 1990 under Public Law 101-508 and its implementing regulations.
- (2) The implementation of a Medicaid retrospective and prospective DUR program as outlined in this chapter, including the approval of software programs to be used by the pharmacist for prospective DUR and recommendations concerning the provisions of the contractual agreement between the state and any other entity that will be processing and reviewing Medicaid drug claims and profiles for the DUR program under this chapter.
- (3) The development and application of the predetermined criteria and standards for appropriate prescribing to be used in retrospective and prospective DUR to ensure that such criteria and standards for appropriate prescribing are based on the compendia and developed with professional input with provisions for timely revisions and assessments as necessary.
- (4) The development, selection, application, and assessment of interventions for physicians, pharmacists, and patients that are educational and not punitive in nature.
- (5) The publication of an annual report that must be subject to public comment before issuance to the federal Department of Health and Human Services and to the Indiana legislative council by December 1 of each year.
- (6) The development of a working agreement for the board to clarify the areas of responsibility with related boards or agencies, including the following:
 - (A) The Indiana board of pharmacy.

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- (B) The medical licensing board of Indiana.
- (C) The SURS staff.
- (7) The establishment of a grievance and appeals process for physicians or pharmacists under this chapter.
- (8) The publication and dissemination of educational information to physicians and pharmacists regarding the board and the DUR program, including information on the following:
 - (A) Identifying and reducing the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and recipients.
 - (B) Potential or actual severe or adverse reactions to drugs.
 - (C) Therapeutic appropriateness.
 - (D) Overutilization or underutilization.
 - (E) Appropriate use of generic drugs.
 - (F) Therapeutic duplication.
 - (G) Drug-disease contraindications.
 - (H) Drug-drug interactions.
 - (I) Incorrect drug dosage and duration of drug treatment.
 - (J) Drug allergy interactions.
 - (K) Clinical abuse and misuse.
- (9) The adoption and implementation of procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the DUR program that identifies individual physicians, pharmacists, or recipients.
- (10) The implementation of additional drug utilization review with respect to drugs dispensed to residents of nursing facilities shall not be required if the nursing facility is in compliance with the drug regimen procedures under 410 IAC 16.2-3-8 and 42 CFR 483.60.
- (11) The research, development, and approval of a preferred drug list for:
 - (A) Medicaid's fee for service program;
 - (B) Medicaid's primary care case management program; and
 - (C) the primary care case management component of the children's health insurance program under IC 12-17.6;

in consultation with the therapeutics committee.

- (12) The approval of the review and maintenance of the preferred drug list at least two (2) times per year.
- (13) The preparation and submission of a report concerning the preferred drug list at least two (2) times per year to the select joint

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- commission on Medicaid oversight established by IC 2-5-26-3.
- (14) The collection of data reflecting prescribing patterns related to treatment of children diagnosed with attention deficit disorder or attention deficit hyperactivity disorder.
- (b) The board shall use the clinical expertise of the therapeutics committee in developing a preferred drug list. The board shall also consider expert testimony in the development of a preferred drug list.
- (c) In researching and developing a preferred drug list under subsection (a)(11), the board shall do the following:
 - (1) Use literature abstracting technology.
 - (2) Use commonly accepted guidance principles of disease management.
 - (3) Develop therapeutic classifications for the preferred drug list.
 - (4) Give primary consideration to the clinical efficacy or appropriateness of a particular drug in treating a specific medical condition.
 - (5) Include in any cost effectiveness considerations the cost implications of other components of the state's Medicaid program and other state funded programs.
- (d) Prior authorization is required for coverage under a program described in subsection (a)(11) of a drug that is not included on has been excluded from the preferred drug list.
- (e) The board shall determine whether to include a single source covered outpatient drug that is newly approved by the federal Food and Drug Administration on the preferred drug list not later than sixty (60) days after the date **on which the manufacturer notifies the board in writing** of the drug's approval. However, if the board determines that there is inadequate information about the drug available to the board to make a determination, the board may have an additional sixty (60) days to make a determination from the date that the board receives adequate information to perform the board's review. Prior authorization may not be automatically required for a single source drug that is newly approved by the federal Food and Drug Administration, and that is:
 - (1) in a therapeutic classification:
 - (A) that has not been reviewed by the board; and
 - (B) for which prior authorization is not required; or
 - (2) the sole drug in a new therapeutic classification that has not been reviewed by the board.

pending a determination by the board under this chapter.

- (f) The board may not exclude a drug from the preferred drug list based solely on price.
 - (g) The following requirements apply to a preferred drug list



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developed under subsection (a)(11):

- (1) Except as provided by IC 12-15-35.5-3(b), the office or the board may require prior authorization for a drug that is included on the preferred drug list under the following circumstances:
 - (A) To override a prospective drug utilization review alert.
 - (B) To permit reimbursement for a medically necessary brand name drug that is subject to generic substitution under IC 16-42-22-10.
 - (C) To prevent fraud, abuse, waste, overutilization, or inappropriate utilization.
 - (D) To permit implementation of a disease management program.
 - (E) To implement other initiatives permitted by state or federal law
- (2) All drugs described in IC 12-15-35.5-3(b) must be included on the preferred drug list.
- (3) The office may add a new single source drug that has been approved by the federal Food and Drug Administration to the preferred drug list without prior approval from the board.
- (4) The board may add a new single source drug that has been approved by the federal Food and Drug Administration to the preferred drug list.
- (h) At least two (2) times each year, the board shall provide a report to the select joint commission on Medicaid oversight established by IC 2-5-26-3. The report must contain the following information:
 - (1) The cost of administering the preferred drug list.
 - (2) Any increase in Medicaid physician, laboratory, or hospital costs or in other state funded programs as a result of the preferred drug list.
 - (3) The impact of the preferred drug list on the ability of a Medicaid recipient to obtain prescription drugs.
 - (4) The number of times prior authorization was requested, and the number of times prior authorization was:
 - (A) approved; and
 - (B) disapproved.
- (i) The board shall provide the first report required under subsection (h) not later than six (6) months after the board submits an initial preferred drug list to the office.

SECTION 2. IC 12-15-35-28.7, AS ADDED BY P.L.107-2002, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 28.7. (a) The board shall submit the initial approved preferred drug list to the office not later than August 1, 2002.

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- (b) Except as permitted under subsection (g), the office may not further restrict the status of a drug in the Medicaid program or the children's health insurance program until the board reviews a therapeutic classification and the office implements the therapeutic classification on the preferred drug list.
- (c) The office shall provide advance notice to providers of the contents of the preferred drug list submitted by the board under subsection (a).
- (d) Notwithstanding IC 12-15-13-6, the office shall implement any change in the preferred drug list not later than thirty (30) days after the date the board submits the amended list to the office.
- (e) Except as provided by section 28(g)(3) of this chapter, the office may not implement a preferred drug list or an amendment to the preferred drug list that has not been approved by the board.
- (f) The office may not require prior authorization for a drug that is excluded from the preferred drug list unless the board has made the determinations required under section 35 of this chapter.
- (g) The office may adopt rules under IC 4-22-2 necessary to carry out this chapter.

SECTION 3. IC 12-15-35-43.5, AS ADDED BY P.L.107-2002, SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 43.5. (a) The board, the therapeutics committee, or the office may not release proprietary or confidential information obtained as part of the development, implementation, or maintenance of a preferred drug list under this chapter.

(b) Information described in subsection (a) is confidential for purposes of IC 5-14-3-4(a)(1).

SECTION 4. IC 12-15-35.5-2.5, AS ADDED BY P.L.107-2002, SECTION 23, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 2.5. As used in this chapter, "unrestricted access" means the ability of a recipient to obtain a prescribed drug without being subject to limits or preferences imposed by the office or the board for the purpose of cost savings except to address situations described in IC 12-15-35-28(a)(8)(A) through (K) and as provided under IC 12-15-35-8 and section 7 of this chapter."

Page 2, line 5, after "act;" insert "and".

Page 2, line 11, delete "; and" and insert ".".

Page 2, delete lines 12 through 13.











Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1458 as introduced.)

BROWN C, Chair

Committee Vote: yeas 10, nays 0.

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Ways and Means, to which was referred House Bill 1458, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 6, line 27, delete "that:" and insert "under the following circumstances:".

Page 6, line 28, delete "access" and insert "Access".

Page 6, line 30, delete "act; and" and insert "act.".

Page 6, line 31, delete "access" and insert "Access".

Page 6, between lines 36 and 37, begin a new line block indented and insert:

"(3) The office may implement the same preferred drug list that is used in the state Medicaid program.".

and when so amended that said bill do pass.

(Reference is to HB 1458 as printed February 20, 2003.)

CRAWFORD, Chair

Committee Vote: yeas 26, nays 0.

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COMMITTEE REPORT

Mr. President: The Senate Committee on Health and Provider Services, to which was referred House Bill No. 1458, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 2-5-26-15, AS ADDED BY P.L.256-2001, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 15. This chapter expires December 31, 2003."

Page 3, line 36, reset in roman "is not included on".

Page 3, line 36, delete "has".

Page 3, line 37, delete "been excluded from".

Page 4, line 5, reset in roman "automatically".

Page 4, line 6, reset in roman "and that is:".

Page 4, reset in roman lines 7 through 11.

Page 4, delete line 12.

Page 4, line 17, delete "Except as provided by IC 12-15-35.5-3(b), the" and insert "The".

Page 6, delete lines 37 through 38.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1458 as printed February 28, 2003.)

MILLER, Chairperson

Committee Vote: Yeas 10, Nays 0.

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